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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05027					05026				
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Harford ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				c. LENGTH OF STAY IN 1b 3 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, 12-2				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pratt Nursing Home					d. STREET ADDRESS 12 N. Phila. Blvd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Bertha Aaronson			4. DATE OF DEATH Month Day Year April 6 1967						
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 3, 1875		9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Harford County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Wilson				14. MOTHER'S MAIDEN NAME Jane Cullinson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Wilson Aaronson, Aberdeen, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic + senile cardiovascular + cerebral DUE TO Vascular disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized spastic paralysis.								INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from 5-14, 1964, to April, 1967, that (we) last saw the deceased alive on 4-3, 1967, and that death occurred at 6:30 AM, from the causes and on the date stated above.									
22a. SIGNATURE Jay S. Barnhart, Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 6, 1967			
22c. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr. M.D.				22d. ADDRESS North East, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8 April 67		23c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery		23d. LOCATION (City, town or county) (State) Perryman, (Harford) Md.			
24. FUNERAL DIRECTOR Walter Macomber Jr.				Funeral Home Aberdeen, Md.		REC'D BY REGISTRAR DATE APR 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05028

## CERTIFICATE OF DEATH

05027

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				d. STREET ADDRESS <b>27-1</b>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>DORSEY</b> Last <b>BUDD</b>				4. DATE OF DEATH Month <b>April</b> , Day <b>18</b> , Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December, 26, 1886</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry D. Budd.</b>				14. MOTHER'S MAIDEN NAME <b>Maria Ferguson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>221-03-2509</b>		17. INFORMANT Address <b>Harry Budd Jr. P.O. Box 37, Port Penn, Del. 19731</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Abdominal Aorta</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gouty arthritis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>  <b>years</b>
20a. AGONY OR PAIN (If either, notify medical examiner) <b>Gouty arthritis</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1 Mar 67</b> , 19 <b>67</b> , to <b>18 Apr</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>12 Apr 67</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Wallace Obenshain</b>				22b. DATE SIGNED <b>18 Apr. 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>	
22d. ADDRESS <b>Cecilton, Md. 21913</b>				22e. ADDRESS <b>Millington, Md. 21651</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April, 22, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stephens Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Earleville, Cecil Co; Md.</b>	
24. FUNERAL DIRECTOR <b>Edward Fellows</b>				25a. REC'D BY REGISTRAR <b>APR 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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*Stroph. laticornis* Doherty

2010-2011-2012-2013-2014-2015-2016-2017-2018-2019-2020-2021-2022-2023-2024-2025-2026-2027-2028-2029-2030-2031-2032-2033-2034-2035-2036-2037-2038-2039-2040-2041-2042-2043-2044-2045-2046-2047-2048-2049-2050-2051-2052-2053-2054-2055-2056-2057-2058-2059-2060-2061-2062-2063-2064-2065-2066-2067-2068-2069-2070-2071-2072-2073-2074-2075-2076-2077-2078-2079-2080-2081-2082-2083-2084-2085-2086-2087-2088-2089-2090-2091-2092-2093-2094-2095-2096-2097-2098-2099-2100-2101-2102-2103-2104-2105-2106-2107-2108-2109-2110-2111-2112-2113-2114-2115-2116-2117-2118-2119-2120-2121-2122-2123-2124-2125-2126-2127-2128-2129-2130-2131-2132-2133-2134-2135-2136-2137-2138-2139-2140-2141-2142-2143-2144-2145-2146-2147-2148-2149-2150-2151-2152-2153-2154-2155-2156-2157-2158-2159-2160-2161-2162-2163-2164-2165-2166-2167-2168-2169-2170-2171-2172-2173-2174-2175-2176-2177-2178-2179-2180-2181-2182-2183-2184-2185-2186-2187-2188-2189-2190-2191-2192-2193-2194-2195-2196-2197-2198-2199-2200-2201-2202-2203-2204-2205-2206-2207-2208-2209-2210-2211-2212-2213-2214-2215-2216-2217-2218-2219-2220-2221-2222-2223-2224-2225-2226-2227-2228-2229-2230-2231-2232-2233-2234-2235-2236-2237-2238-2239-2240-2241-2242-2243-2244-2245-2246-2247-2248-2249-2250-2251-2252-2253-2254-2255-2256-2257-2258-2259-2260-2261-2262-2263-2264-2265-2266-2267-2268-2269-2270-2271-2272-2273-2274-2275-2276-2277-2278-2279-2280-2281-2282-2283-2284-2285-2286-2287-2288-2289-2290-2291-2292-2293-2294-2295-2296-2297-2298-2299-2300-2301-2302-2303-2304-2305-2306-2307-2308-2309-2310-2311-2312-2313-2314-2315-2316-2317-2318-2319-2320-2321-2322-2323-2324-2325-2326-2327-2328-2329-2330-2331-2332-2333-2334-2335-2336-2337-2338-2339-2340-2341-2342-2343-2344-2345-2346-2347-2348-2349-2350-2351-2352-2353-2354-2355-2356-2357-2358-2359-2360-2361-2362-2363-2364-2365-2366-2367-2368-2369-2370-2371-2372-2373-2374-2375-2376-2377-2378-2379-2380-2381-2382-2383-2384-2385-2386-2387-2388-2389-2390-2391-2392-2393-2394-2395-2396-2397-2398-2399-2400-2401-2402-2403-2404-2405-2406-2407-2408-2409-2410-2411-2412-2413-2414-2415-2416-2417-2418-2419-2420-2421-2422-2423-2424-2425-2426-2427-2428-2429-2430-2431-2432-2433-2434-2435-2436-2437-2438-2439-2440-2441-2442-2443-2444-2445-2446-2447-2448-2449-2450-2451-2452-2453-2454-2455-2456-2457-2458-2459-2460-2461-2462-2463-2464-2465-2466-2467-2468-2469-2470-2471-2472-2473-2474-2475-2476-2477-2478-2479-2480-2481-2482-2483-2484-2485-2486-2487-2488-2489-2490-2491-2492-2493-2494-2495-2496-2497-2498-2499-2500-2501-2502-2503-2504-2505-2506-2507-2508-2509-2510-2511-2512-2513-2514-2515-2516-2517-2518-2519-2520-2521-2522-2523-2524-2525-2526-2527-2528-2529-2530-2531-2532-2533-2534-2535-2536-2537-2538-2539-2540-2541-2542-2543-2544-2545-2546-2547-2548-2549-2550-2551-2552-2553-2554-2555-2556-2557-2558-2559-2560-2561-2562-2563-2564-2565-2566-2567-2568-2569-2570-2571-2572-2573-2574-2575-2576-2577-2578-2579-2580-2581-2582-2583-2584-2585-2586-2587-2588-2589-2590-2591-2592-2593-2594-2595-2596-2597-2598-2599-2600-2601-2602-2603-2604-2605-2606-2607-2608-2609-2610-2611-2612-2613-2614-2615-2616-2617-2618-2619-2620-2621-2622-2623-2624-2625-2626-2627-2628-2629-2630-2631-2632-2633-2634-2635-2636-2637-2638-2639-2640-2641-2642-2643-2644-2645-2646-2647-2648-2649-2650-2651-2652-2653-2654-2655-2656-2657-2658-2659-2660-2661-2662-2663-2664-2665-2666-2667-2668-2669-2670-2671-2672-2673-2674-2675-2676-2677-2678-2679-2680-2681-2682-2683-2684-2685-2686-2687-2688-2689-2690-2691-2692-2693-2694-2695-2696-2697-2698-2699-2700-2701-2702-2703-2704-2705-2706-2707-2708-2709-2710-2711-2712-2713-2714-2715-2716-2717-2718-2719-2720-2721-2722-2723-2724-2725-2726-2727-2728-2729-2730-2731-2732-2733-2734-2735-2736-2737-2738-2739-2740-2741-2742-2743-2744-2745-2746-2747-2748-2749-2750-2751-2752-2753-2754-2755-2756-2757-2758-2759-2760-2761-2762-2763-2764-2765-2766-2767-2768-2769-2770-2771-2772-2773-2774-2775-2776-2777-2778-2779-2780-2781-2782-2783-2784-2785-2786-2787-2788-2789-2790-2791-2792-2793-2794-2795-2796-2797-2798-2799-2800-2801-2802-2803-2804-2805-2806-2807-2808-2809-2810-2811-2812-2813-2814-2815-2816-2817-2818-2819-2820-2821-2822-2823-2824-2825-2826-2827-2828

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TO: STAFF

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05028

## CERTIFICATE OF DEATH

05028

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			c. LENGTH OF STAY IN lb <b>1 week</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fair Hill</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				d. STREET ADDRESS <b>Elkton, Md. RFD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>Edna</b> First <b>C.</b> Middle <b>BURKE</b> Last				<b>4. DATE OF DEATH</b> Month <b>4</b> Day <b>23</b> Year <b>1967</b>				
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>2/28/1878</b>		
<b>9. AGE</b> (In years last birthday) yrs. <b>89</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>				<b>13. FATHER'S NAME</b> <b>George T. Peterson</b>				
<b>14. MOTHER'S MAIDEN NAME</b> <b>Isabell Willis</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>N</b> (If yes give war or dates of service)				
<b>16. SOCIAL SECURITY NO.</b> <b>222-14-1170</b>				<b>17. INFORMANT</b> <b>Mrs. Margie B. Mackie</b> Address <b>Elkton, Md RD# 4</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uterine Hemorrhage</b> DUE TO (b) <b>Uterine Fibroids</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>years</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased, from <u>4/16</u>, 19<u>67</u>, to <u>4/23</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>4/23</u>, 19<u>67</u>, and that death occurred at <u>9:55 PM</u>, from causes and on the date stated above.</b>								
<b>22a. SIGNATURE</b> <i>John A. Fischer</i>				<b>22b. DATE SIGNED</b> <b>4/25/67</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>John A. Fischer</b>		
<b>22d. ADDRESS</b> <b>ELKTON, Md</b>				<b>22e. M.D. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4/26/67</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cherry Hill Cem.</b>		<b>23d. LOCATION</b> (City or Town) (County) (State) <b>Cherry Hill, Maryland</b>		
<b>24. FUNERAL DIRECTOR</b> <b>R. T. Jones</b> ADDRESS <b>Newark, Delaware</b>				<b>25a. REC'D BY REGISTRAR</b> <b>APR 27 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles J. Jones</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MADRYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
05030		CERTIFICATE OF DEATH				05029				
1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md. NONE</u> b. COUNTY <u>Cecil</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELRTON</u>			c. LENGTH OF STAY IN TB <u>1 HR.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NONE</u> <u>07-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>					d. STREET ADDRESS <u>NONE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>BABY BOY</u> First <u>Charles</u> Middle <u>Wick</u> Last <u>Wick</u>					4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-3-67</u>		9. AGE (In years lost birthday) yrs. <u>1</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ELRTON, MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>HARRY EDWARD CHADWICK</u>					14. MOTHER'S MAIDEN NAME <u>BETTY LEE GILL</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HARRY E. CHADWICK FARMINGTON</u> Address <u>FAP.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>10 hr.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>4/3</u> , 19 <u>67</u> , to <u>4/3</u> , 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>4/3</u> , 19 <u>67</u> , and that death occurred at _____ M, from causes on and on the date stated above.										
22a. SIGNATURE <u>Joseph G. Lanzi</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH G. LANZI</u>					22d. ADDRESS <u>ELRTON, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-6-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ELRTON</u>		23d. LOCATION (City or Town) (County) (State) <u>ELRTON CECIL MD</u>				
24. FUNERAL DIRECTOR <u>Robert Gault</u> <u>PIPPIN FUNERAL HOME</u>					ADDRESS <u>ELRTON</u>		25a. REC'D BY REGISTRAR <u>APR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15  
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05031

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05030

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN lb <b>Elkton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Elk River</b>				d. STREET ADDRESS <b>R.D.# 1</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>F.</b> Last <b>Coppage, Sr.</b>				4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 28, 1921</b>	9. AGE (In years last birthday) <b>46</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman Roadgrader Guage Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Eugene Coppage</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-20-5708</b>		14. MOTHER'S MAIDEN NAME <b>Rita McBride</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> 9298 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Drowned while attempting to recover drifting boat</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>4-22-67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>ELK RIVER</b>		20f. (City or town) (County) (State) <b>Elkton Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Tillman D. Johnson M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Tillman D. Johnson M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>Elkton, Md. 4-26-67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/26/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Park, Elkton, Md.</b>		23d. LOCATION (City or Town) (County) (State) <b>Elkton Cecil Md.</b>	
24. FUNERAL DIRECTOR <b>Hicks Home for Funerals, Elkton, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05032

CERTIFICATE OF DEATH

05031

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u> 07-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				d. STREET ADDRESS <u>503 North St</u>			
3. NAME OF DECEASED (Type or print) <u>HENRY WALTER duBose, Jr</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/14/1895</u>	
				9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R. Funeral Business</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FUNERAL HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>First Name UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>Reginz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-03-7877</u>		17. INFORMANT Address <u>H. WALTER duBose, Jr ELKTON</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>William D. Wapner, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/2/67</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>4/5/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ELKTON Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>ELKTON CECIL Md</u>	
24. FUNERAL DIRECTOR <u>H. Walter duBose, Jr</u>				ADDRESS <u>503 North St ELKTON</u>		25a. REC'D BY REGISTRAR DATE <u>APR 4 1967</u>	
						25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

05031

COPIES OF DEATH

05031

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Upper Transition

Active sectors

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05033

## CERTIFICATE OF DEATH

05032

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>82 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital</b>		d. STREET ADDRESS <b>625 K St. S.E.</b>	
3. NAME OF DECEASED (Type or print) First <b>Sipo</b> Middle <b>R.</b> Last <b>ENGLISH</b>		4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-19</b>
9. AGE (In years lost birthday) <b>47 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Columbia, S.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Albert English - Deceased</b>	
14. MOTHER'S MAIDEN NAME <b>Susie Nelson - Deceased</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW II</b>	
16. SOCIAL SECURITY NO. <b>229-07-02-96</b>		17. INFORMANT <b>VA Hospital Records - Perry Point, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastric Carcinoma</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized metastases</b> DUE TO (c) <b>including cerebral metastases</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (If at this hospital) attended the deceased from <b>1-9-67</b> , 19 to <b>4-1-67</b> , 19 <del>that (if two) last saw the deceased alive on</del> and that death occurred at <b>2:20 P.M.</b> from causes and on the date stated above.	
22a. SIGNATURE <b>Refrad G. Gillis</b>		22b. DATE SIGNED <b>4 1 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. G. GILLIS, M.D.</b>		22d. ADDRESS <b>VA Hospital - Perry Point, Maryland</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-7-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Landover, Maryland Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>MALVAN &amp; SCHEY INC.</b>		25a. REC'D BY REGISTRAR <b>APR 5 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>424 R St., N.W. Wash DC</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																																		
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																																		
05034			CERTIFICATE OF DEATH				05033																											
Item #7 Film #0388 4/26/67																																		
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> c. LENGTH OF STAY IN 1b <b>year</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>22 Leedom Rd Elkton Md.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>22 Leedom Rd Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton Maryland</b> d. STREET ADDRESS <b>Elkton Maryland</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																													
3. NAME OF DECEASED (Type or print) First Middle Last <b>Grace Leona Gibson</b>			4. DATE OF DEATH Month Day Year <b>17 April 1967</b>		5. SEX <b>female</b>					6. COLOR OR RACE <b>white</b>					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>8 Feb 1892</b>					9. AGE (in years last birthday) <b>75</b> yrs.					10. FUNERAL 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <b>Big Spring Maryland</b>					12. CITIZEN OF WHAT COUNTRY? <b>USA</b>																			
13. FATHER'S NAME <b>Mentor P Moore</b>					14. MOTHER'S MAIDEN NAME <b>Phyllis Gibson</b>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. (If yes give war or dates of service)					17. INFORMANT <b>Kay Reynolds</b> Address <b>Port Deposit, Md.</b>														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> (c) <b>Marked sclerosis of aorta with mesenteric artery insufficiency</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>10 min years</b>																								
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)																			
21. I certify that (I) (this hospital) attended the deceased from <b>1 Mar 67</b> to <b>17 Apr 67</b> , that (I) (we) last saw the deceased alive on <b>17 Apr 67</b> , and that death occurred at <b>11:45 A.M.</b> on the causes and on the date stated above.										22a. SIGNATURE <b>Wallace Obenshain</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b> 22d. ADDRESS <b>Cecilton, Md.</b>					22b. DATE SIGNED <b>20 Apr 67</b>																			
23a. (BURIAL, CREMATION, REMOVAL) (Specify) <b>4/20/67</b>					23b. DATE THEREOF <b>4/20/67</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>					23d. LOCATION (City, town or county) (State) <b>Harold Chase Md</b>																			
24. FUNERAL DIRECTOR <b>Charles Judge</b>					25a. REC'D BY REGISTRAR <b>APR 24 1967</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>																								

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**TITIAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03031

1. PLACE OF DEATH a. COUNTY <u>CECIL</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b <u>1 WEEK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNCOM HOSPITAL</u>		d. STREET ADDRESS <u>HOLLYWOOD BEACH</u>	
3. NAME OF DECEASED (Type or print) <u>HOWARD</u>		4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7-3-1891</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LABOR</u>	
11. BIRTHPLACE (State or foreign country) <u>HARDMORE, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARVEY GILLINGHAM</u>		14. MOTHER'S MAIDEN NAME <u>NO INFO</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>183-21-6455A</u>	
17. INFORMANT <u>HARVEY GILLINGHAM</u>		Address <u>FT. PIERCE, FLA.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>903.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>HYPERTENSIVE C.V. DISEASE</u> DUE TO (c) <u>FALL IN YARD AT HOME</u>		INTERVAL BETWEEN ONSET AND DEATH <u>ONE WEEK</u> <u>SERIAL</u> <u>YEARS</u> <u>ONE WEEK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>HOLLYWOOD BEACH</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3/27</u> 19 <u>67</u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. (City or town) <u>HOLLYWOOD BEACH</u> (County) <u>Cecil</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <u>H. Davis</u> M.D.		DATE SIGNED <u>4-6-67</u>	
EXAMINER'S NAME (Type) <u>HENRY V. DAVIS M.D.</u>		Address (Street, city, town, or county) <u>CHESAPEAKE CITY MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-6-67</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL</u>		22d. LOCATION (City, town, or county) (State) <u>CHESAPEAKE CITY MD</u>	
23. FUNERAL DIRECTOR <u>Pippin Funeral Home</u>		24a. REC'D BY REGISTRAR <u>APR 7 1967</u>	
ADDRESS <u>ELKTON, MD</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
05036					05035									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY <b>Cecil</b> MARYLAND					a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>									
c. LENGTH OF STAY IN 1b <b>1 yr.</b>					d. STREET ADDRESS <b>R.D.1</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Morgan Nursing Home</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last <b>Catharine Ann Hague</b>					Month Day Year <b>April 6th, 19 67</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 28, 1887</b>		9. AGE (In years last birthday) <b>79 yrs.</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME <b>Frances Finn</b>					14. MOTHER'S MAIDEN NAME <b>Mary Clara Rambo</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>----</b>					17. INFORMANT Address <b>Mrs. Rose H. Nickle, Elkton, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorag with rt. Hemaplegia</b> DUE TO <b>Hypertensive Cardio-Renal Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerous</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>15 yrs.</b> <b>15 yrs.</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>March 25/67</b>		20f. (City or town) (County) (State) <b>April 6/67</b>							
21. I certify that (I) (this hospital) attended the deceased from <b>April 6/67</b> to <b>April 6/67</b> , that (I) (we) last saw the deceased alive on <b>April 6/67</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Walter H. Lee</b> M.D.					22b. DATE SIGNED <b>4/11/67</b>									
22c. PHYSICIAN'S NAME (Type) <b>Walter H. Lee</b>					22d. ADDRESS <b>206 S. Broad St. Middletown, Del.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4/10/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Immaculate Conception</b>			23d. LOCATION (City, town or county) (State) <b>Elkton, Md.</b>						
24. FUNERAL DIRECTOR <b>Ralph E. Hicks</b> <b>Hicks Home for Funerals, Elkton, Md.</b>					25a. REC'D BY REGISTRAR <b>APR 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

15203

15203

Cecil

Barryland

Cecil

Thessalonike City

1 yr.

Elkton

Norman Mainline Home

R.D.1

Guthrie Ann Home

April 20th, 1957

Female White

April 20, 1957 to

Housewife

Maryland

U.S.A.

Frances Elin

Very close home

No

Mrs. Ross W. Nichols, Elkton, Md.

Walter H. Lee

208 S. Broad St. Wilmington, Del.

Wanted

Immediate Conception

Elkton, Md.

Wilmington for Amelia, Md.

APR 18 1957



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
05037		CERTIFICATE OF DEATH		05036	
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN Yr 26 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital of Cecil County			d. STREET ADDRESS 228 Locust Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) John E		First Middle Last Hollenbaugh, Sr		4. DATE OF DEATH April 24 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1919		9. AGE (In years last birthday) 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mixer for brick		10b. KIND OF BUSINESS OR INDUSTRY Brick Factory		11. BIRTHPLACE (County & State, or foreign country) Shippenburg, Pa.	
13. FATHER'S NAME Samuel A. Hollenbaugh			14. MOTHER'S MAIDEN NAME Anna Jane Piper		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 2nd World War		16. SOCIAL SECURITY NO. 180-18-8064		17. INFORMANT Mrs. Anne Hollenbaugh Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Coronary Occlusion DUE TO (b) Chronic Myocarditis DUE TO (c) Hypertension, Adentis					INTERVAL BETWEEN ONSET AND DEATH 1961 1963
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (the hospital) attended the deceased from 3/27/1967, to 4/24/1967, that (I) (the hospital) saw the deceased alive on 4/27/1967, and that death occurred at 4:20 M, from causes and on the date stated above.					
22a. SIGNATURE James L. Johnson		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/25/67	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 East High St., Elkton, Md. Cecil			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/28/67		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery	
23d. LOCATION (City or Town) Newville, Pa.		23e. (County)		23f. (State)	
24. FUNERAL DIRECTOR Ralph E. Hicks		ADDRESS Hicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR MAY 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

05036

05037

1983 Tourist Lane

180-16-0004

Prospect Hill Cemetery, Nashville, Pa.

Links Home for Puppies, Union, Pa.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## 05038

05037

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		071	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.D # 3 (Leeds)</b>				d. STREET ADDRESS <b>R.D # 3 (Leeds)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elmer</b>		First <b>H.</b>		Middle <b>Lake</b>		Last	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 8, 1909</b>	
9. AGE (In years last birthday) yrs. <b>57</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Govern.</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George N. Lake</b>				14. MOTHER'S MAIDEN NAME <b>Maude Harman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1929-36</b>		17. INFORMANT (Self) (1965) Address <b>Elmer H. Lake, Elkton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Myocardial Infarction</b> (c) <b>Coronary Thrombosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Rolando A. Najera</b> M.D. EXAMINER'S NAME (Type) <b>Rolando A. Najera</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
22. DATE SIGNED <b>4/8/67</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/11/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Methodist Cemetery, Union, Cecil Co. Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Hicks Home for Funerals, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Joyce</b>	

VR A15ME (5)  
6M 1/66

130031

05332

Coal

Washing

Coal

Washing

Coal

( 1 1/2 tons )

( 1 1/2 tons )

April 1937

May 1937

U.S. Government

Washing

Washing

Washing

Washing

Washing

Washing

Washing

05039

## CERTIFICATE OF DEATH

05038

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>Route # 2, Box 51</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>OSCAR</b> Middle <b>D.</b> Last <b>MAHALA</b>				4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-29-88</b>	9. AGE (In years last birthday) yrs. <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Mahala (D)</b>				14. MOTHER'S MAIDEN NAME <b>Abbie Osborne (D)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>213-03-1112</b>		17. INFORMANT Address <b>VA Hospital Records, Perry Point, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of heart, massive</b> DUE TO (b) <b>Acute myocardial infarction</b> DUE TO (c) <b>Coronary thrombosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>5-7 days</b> <b>5-7 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <del>the deceased</del> <b>XX</b> (this hospital) attended the deceased from <b>March 30, 1967</b> , to <b>April 3, 1967</b> , that death occurred on <b>April 3, 1967</b> , and that death occurred at <b>1:10 P.M.</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>J. R. Garcia M.D.</b>				22b. DATE SIGNED <b>4-4-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>J. R. GARCIA, M.D.</b>				22d. ADDRESS <b>VAH, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/6/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Park, Elkton, Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Hicks Funeral Home, Elkton, Md.</b>				25a. REGISTERED <b>APR 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Figure 14. Schematic of the proposed system.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05040

05039

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun Rural</b>		c. LENGTH OF STAY IN lb <b>3 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowingo Rural</b>		d. STREET ADDRESS <b>R.F.D. # 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Frances Nickle</b>		4. DATE OF DEATH Month <b>4</b> Day <b>11</b> Year <b>1967</b>	
5. SEX <b>Femal</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-18-1871</b>
9. AGE (In years last birthday) <b>96</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>11</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Work</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cecil Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stephen E. Nickle</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Bigley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-52-2979</b>	
17. INFORMANT <b>Chas. Nickle</b>		Address <b>Conowingo Md. R.D.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> DUE TO <b>Arteriosclerotic Cardiac Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiac Vascular Disease</b> (c) <b>Arteriosclerotic Cardiac Vascular Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 19 <b>66</b> , to <b>April</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>April</b> 19 <b>67</b> , and that death occurred at <b>4:30 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Ernest W. Seiter M.D.</b>		22b. DATE SIGNED <b>4-12-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ernest W. Seiter M.D.</b>		22d. ADDRESS <b>28 W. Cherry St. Rising Sun, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-13-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Cem</b>	23d. LOCATION (City or Town) (County) (State) <b>Colora Cecil Md.</b>
24. FUNERAL DIRECTOR <b>John M. Miller</b>		25a. REC'D BY REGISTRAR <b>Rising Sun, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>John M. Miller</b>		DATE <b>APR 13 1967</b>	

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05041

CERTIFICATE OF DEATH

05040

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 52 Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake, City		d. STREET ADDRESS 171	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital Of Cecil County		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Louis Ortynski		4. DATE OF DEATH Month Day Year 4 12 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/19/95
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 Year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM	
11. BIRTHPLACE (County & State, or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ignatius Ortynski		14. MOTHER'S MAIDEN NAME Lillian L'tinsky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-40-1870	
17. INFORMANT Patient		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Acute Cardiac Failure DUE TO (b) Chronic Myocarditis DUE TO (c) Pulmonary Edema, Diabetes		INTERVAL BETWEEN ONSET AND DEATH 3-Days 5-Years 5-Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 4/9/67, 19 67, to 4/12/67, 19 67, that (I) (we) last saw the deceased alive on 4/12/67, 19 67, and that death occurred at 10:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE James L. Johnson		22b. DATE SIGNED 4/14/67	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 East High St., Elkton, Md. Cecil	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-17-67	
23c. NAME OF CEMETERY OR CREMATORY ST. ROSE OF LIMA		23d. LOCATION (City or Town) (County) (State) CHESAPEAKE CITY, CEIL MD.	
24. FUNERAL DIRECTOR Pippin Funeral Home		25a. REC'D BY REGISTRAR APR 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05042

CERTIFICATE OF DEATH

05041

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PERRY POINT</b> c. LENGTH OF STAY IN 1b <b>1 Mo 15 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DELAWARE</b> b. COUNTY <b>NEW CASTLE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wilmington</b> d. STREET ADDRESS <b>3035 N. Market</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EDWARD L. PERRY</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-8-83</b>	9. AGE (In years last birthday) <b>83 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>New Castle Wilmington</b>	
13. FATHER'S NAME <b>Elwood Perry</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>222 03 23 10</b>		17. INFORMANT <b>VA Records</b> Address <b>VAH, Perry Point, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4200</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease with congestive</b> DUE TO <b>Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Renal Failure with Uremia</b> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 6</b> , 19 <b>67</b> , to <b>April 21</b> , 19 <b>67</b> , and that death occurred at <b>4:35 P.M.</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Joaquin R. Garcia</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOAQUIN R. GARCIA, M.D.</b>		22d. ADDRESS <b>VAH, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Removal</b>		23b. DATE THEREOF <b>4/26/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Silver Brook Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Wilmington New Castle Del.</b>		25a. REC'D BY REGISTRAR <b>APR 27 1967</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05043

## CERTIFICATE OF DEATH

05042

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. LENGTH OF STAY IN 1b <u>5 MINUTES</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>				e. STREET ADDRESS <u>NONE</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>GENNIE ELIZABETH POE</u>				4. DATE OF DEATH Month Day Year <u>4 3 1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-5-1889</u>			
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>TENNESSEE</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>DANIEL ARNOLD</u>				14. MOTHER'S MAIDEN NAME <u>ALICE OSBORNE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>PHOEBE POE</u> Address <u>NORTH EAST, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral - vascular accident</u> DUE TO (b) <u>ASCVD.</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral bronchopneumonia</u>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>3-31</u> , 19 <u>67</u> , to <u>4-3</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>4-3</u> , 19 <u>67</u> , and that death occurred at <u>3:45</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Jay S. Barnhart, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>JAY S. BARNHART, JR.</u>				22d. ADDRESS <u>NORTH EAST, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-7-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RHODE CEMETRY</u>		23d. LOCATION (City, town or county) (State) <u>ABINGDON VA</u>			
24. FUNERAL DIRECTOR <u>PIPTIN FUNERAL HOME</u>				25a. REC'D BY REGISTRAR <u>APR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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THE UNIVERSITY OF CHICAGO

LIBRARY

500 EAST 57TH STREET

CHICAGO, ILL. 60637

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THOMAS ARNOLD

PHASE TWO - NORTH

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CHICAGO, ILL. 60637

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CHICAGO, ILL. 60637

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05044

## CERTIFICATE OF DEATH

05043

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Union Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>North East</b> d. STREET ADDRESS <b>R.D. # 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <b>LAURA</b> First <b>Virginia</b> Middle <b>RACINE</b> Last		4. DATE OF DEATH <b>4</b> Month <b>12</b> Day <b>1967</b> Year		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 28, 1921</b>		9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>George M. Davis</b>				14. MOTHER'S MAIDEN NAME <b>Eva R. Cameron</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-14-0198</b>				17. INFORMANT <b>Charles D. Racine, Sr.</b> Address <b>North East, Md</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA of CERVIX</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA of lung</b>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4/11</b> , 1967, to <b>4/12</b> , 1967, that (I) (we) last saw the deceased alive on <b>4/11</b> , 1967, and that death occurred at <b>5:00</b> M. from the causes and on the date stated above.														22a. SIGNATURE <b>John A. Fischer</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/12/67</b>							
22c. PHYSICIAN'S NAME (Type) <b>John A. Fischer</b>				22d. ADDRESS <b>1666 Main, ELKTON, Md</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/16/67</b>				23c. NAME OF CEMETERY OR CREMATORY <b>North East Methodist</b>				23d. LOCATION (City, town or county) (State) <b>North East, Md.</b>			
24. FUNERAL DIRECTOR <b>Ralph E. Hicks</b>				24a. ADDRESS <b>117 E. Cecil Ave.</b>				24b. REC'D BY REGISTRAR <b>Charles Judge</b>				24c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				24d. DATE <b>APR 18 1967</b>							

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95013

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Marjorie

Geoff

North East

Life

Marjorie

R.D. 2

Union Hospital

Virginia

Marjorie Ann, 28, 1921

Marjorie Ann, 28, 1921

Marjorie

Marjorie

Eva H. Cameron

George H. Davis

214-1-198 Charles T. Racine, Jr. North East, Md.

214-1-198

North East Methodist

North East Methodist

Marjorie

117 E. Cecil Ave.

214-1-198 Charles T. Racine, Jr. North East, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
05045										
05044										
1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. LENGTH OF STAY IN 1b <u>5 DAYS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>NR ELKTON</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>UNION HOSPITAL</u>					d. STREET ADDRESS <u>FRENCH TOWN Rd</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>GROVER C. RHOADES</u>					4. DATE OF DEATH Month Day Year <u>APRIL 2 1967</u>					
5. SEX <u>MALE</u>		6. CDLDR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 1, 1892</u>		9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CHESAPEAKE CITY, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>FRANK RHOADES</u>					14. MOTHER'S MAIDEN NAME <u>LUSBY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>221-12-1800</u>		17. INFORMANT Address <u>BENJAMIN F. RHOADES NEWARK, DEL.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral artery hemorrhage</u> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH <u>6 d.</u> <u>Years</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>3-28-</u> 19 <u>67</u> , to <u>4-2-</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-2-</u> 19 <u>67</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>Tillman D. Johnson</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-2-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson</u>					22d. ADDRESS <u>123 Sinsbury Ave., Elkton, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-5-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHERRY HILL CEM.</u>		23d. LOCATION (City, town or county) (State) <u>CHERRY HILL, Md.</u>				
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>					ADDRESS <u>ELKTON, Md.</u>		25a. DATED BY REGISTRAR <u>APR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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05046

## CERTIFICATE OF DEATH

05045

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b> c. LENGTH OF STAY IN lb <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hances Point (R.D.)</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b> d. STREET ADDRESS <b>Hances Point</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Freda P. Rogers</b>		4. DATE OF DEATH Month Day Year <b>April, 27 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1912</b>
9. AGE (In years last birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Peterson</b>		14. MOTHER'S MAIDEN NAME <b>Lenore Lake</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Howard H. Rogers, North East, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis, intra abdominal</b> <b>1950</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Carcinoma of Ovary</b> OUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 mo</b> <b>13 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>--</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>13 Jan</b> , 19 <b>67</b> , to <b>27 Apr. 1</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>27 Apr. 1</b> , 19 <b>67</b> , and that death occurred at <b>7 A. M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Klaus H. Huebner</b>		22b. DATE SIGNED <b>4/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>KLAUS H. HUEBNER</b>		22d. ADDRESS <b>NORTH EAST, M.C.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<b>Burial</b>	<b>4/30/67</b>	<b>Friends Burial Ground, Calvert, Md.</b>	
24. FUNERAL DIRECTOR <b>Ralph E. Hicks</b>		25a. REC'D BY REGISTRAR <b>MAY 1 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Johnes Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05047

CERTIFICATE OF DEATH

05046

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN lb <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun</b> d. STREET ADDRESS <b>Main Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DOMINIC M. SAPONARO</b>		4. DATE OF DEATH Month Day Year <b>April 26 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-22</b>
9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hotel Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Perry Point, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael (L)</b>		14. MOTHER'S MAIDEN NAME <b>Pietrapertosa (L)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>215-16-1965</b>	
17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction - cardiac arrest</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12:20/4-26, 1967</b> , to <b>12:35/4-26 1967</b> and that death occurred at <b>12:35 am</b> from causes and on the date stated above.			
22a. SIGNATURE <b>A. BOYTAR, M.D.</b>		22b. DATE SIGNED <b>4-26-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. BOYTAR, M.D.</b>		22d. ADDRESS <b>VAH, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 28, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Erin Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Havre de Grace, Maryland,</b>
24. FUNERAL DIRECTOR <b>Lee A. Patterson Funeral Home, Perryville,</b>		25a. REC'D BY REGISTRAR <b>MAY 3 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05048

CERTIFICATE OF DEATH

05047

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit Rural</b>		c. LENGTH OF STAY IN 1b <b>Yeares</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hopewell Road</b>		d. STREET ADDRESS <b>Hopewell Road</b>	
3. NAME OF DECEASED (Type or print) <b>Jesse Lillard Shephard</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-30-1904</b>
9. AGE (In years lost birthday) yrs. <b>63</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>63</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harve Farmer</b>		14. MOTHER'S MAIDEN NAME <b>Biner Shephard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-36-7977</b>	
17. INFORMANT <b>Mrs. Jesse Shephard</b>		Address <b>Port Deposit Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Emphysema</b> 5021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BRONCHITIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-7</b> , 1946, to <b>4-4</b> , 1967, that (I) (we) last saw the deceased alive on <b>4-3</b> , 1967, and that death occurred at <b>1:45</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>G.H. Richards Jr.</b>		22b. DATE SIGNED <b>4/5/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>G.H. Richards Jr.</b>		22d. ADDRESS <b>Port Deposit, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-7-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Port Deposit Cecil Md.</b>	
24. FUNERAL DIRECTOR <b>Tyson Funeral Home</b>		25a. REC'D BY REGISTRAR <b>APR 11 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

05047

DEPARTMENT OF HEALTH

05047

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Long Beach, California

Long Beach, California

Hopewell, Ohio

Hopewell, Ohio

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05049

## CERTIFICATE OF DEATH

05048

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Ohio b. COUNTY Summit	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN lb 2 Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Morgan Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ollie Slayman		4. DATE OF DEATH April 23 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining	9. AGE (In years last birthday) yrs. 82
11. BIRTHPLACE (County & State, or foreign country) Syria		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 234-01-0262	
17. INFORMANT Norman Slayman		Address Aliquippa, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Cerebral Vascular Accident DUE TO Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH — —
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital), attended the deceased from April 20, 1967, to April 23, 1967 that (1) (we) last saw the deceased alive on April 20, 1967, and that death occurred at 1:05 P.M. from causes and on the date stated above.			
22a. SIGNATURE Rolando A. Najera		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 4/24/67
22c. PHYSICIAN'S NAME (Type) Rolando A. Najera		22d. ADDRESS 105 E. Main St. Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 27, 1967	23c. NAME OF CEMETERY OR CREMATORY Daily Presby. Cem.	23d. LOCATION (City or Town) (County) (State) Daily West Virginia
24. FUNERAL DIRECTOR Grant Funeral Home Paul R. Cronan		25a. REC'D BY REGISTRAR DATE APR 26 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

25070

0502

FOR STATE  
HEALTH DEPT

05050

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05049

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>York</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	c. LENGTH OF STAY IN lb <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - York</u> 75.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		d. STREET ADDRESS <u>R.D. 9 (3727 Stoneybrook Rd.)</u>	
3. NAME OF DECEASED (Type or print) First <u>Honace</u> Middle <u>Edward</u> Last <u>Spangler, Jr.</u>		4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-21-17</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COMMERCIAL ARTIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>	
11. BIRTHPLACE (State or foreign country) <u>SALISBURY, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Horace E. Spangler</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>II - Navy</u>	
17. INFORMANT <u>Mrs. Phyllis Reed Spangler, York, Pa.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>unk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John M. Byers, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John M. Byers, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED <u>4-8-67</u>		<u>Elkton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>April 12, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>York York Penna.</u>
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME, Donald P. Lee</u>		25. REC'D BY REGISTRAR <u>APR 11 1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02073

02073

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05051						CERTIFICATE OF DEATH			05050		
1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. LENGTH OF STAY IN 1b <u>13 DAYS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EARLEVILLE</u> <u>07-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>UNION HOSPITAL</u>						d. STREET ADDRESS <u>NONE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHESTER</u>			First <u>R.</u> Middle <u>Steinman</u> Last		4. DATE OF DEATH <u>Apr</u> <u>1</u> <u>1967</u>			Month Day Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/24/28</u>		9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LARD MGR.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARINA</u>		11. BIRTHPLACE (County & State, or foreign country) <u>LANCASTER, PA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>J. ADAM WEAVER (FOSTER)</u>						14. MOTHER'S MAIDEN NAME <u>EMMA HOOVER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>MORE 4</u>		17. INFORMANT <u>MRS. JEANNETTE STEINMAN</u>		Address <u>EARLEVILLE MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial rupture</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive anterior infarction</u> DUE TO (c) <u>Arteriosclerotic heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fibrosis left lung with due to Tbc or histoplasmosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>7 minutes</u> <u>11 days</u> <u>11 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>21 Mar</u> , 19 <u>67</u> to <u>1 Apr</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>21 Apr</u> , 19 <u>67</u> , and that death occurred at <u>2 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Wallace Obenshain</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3 Apr 67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wallace Obenshain, M.D.</u>						22d. ADDRESS <u>Cecilton, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>34/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>TRUMBauer LUTHERAN</u>			23d. LOCATION (City, town or county) (State) <u>LEOLA PA.</u>				
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>						ADDRESS <u>ELKTON, MD</u>		25a. REC'D BY REGISTRAR <u>APR 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

05050

05050

WALTERS OPERATIONS, INC. COASTAL, INC.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.)

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

05052

05051

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b <u>2 DAYS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>UNION HOSPITAL</u>				d. STREET ADDRESS <u>254 E. MAIN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>TAYLOR</u>				4. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-28-1886</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAFETERA OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FOOD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES R. THOMSON</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH STANFIELD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>216-48-0931</u>		17. INFORMANT <u>VICTOR S. TAYLOR</u>		Address <u>254 E. MAIN ELKTON, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive cerebral hemorrhage</u> <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic C-V disease with cardiac hypertrophy</u> (c) <u>and valvular insufficiency.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 2</u> , 19 <u>67</u> to <u>April 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 4</u> , 19 <u>67</u> , and that death occurred at <u>6:20</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>S. Ralph Andrews, Jr.</u>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>				22d. ADDRESS <u>233 E. Main St., Elkton, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-7-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ELKTON</u>		23d. LOCATION (City, town or county) (State) <u>ELKTON CECIL MD.</u>	
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>				ADDRESS <u>ELKTON, MD.</u>		25a. REC'D BY REGISTRAR <u>APR 6 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

05002

05002

3 days  
Unknown

*[Handwritten signature]*

x

x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05053					05052				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Cecil					a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton					b. COUNTY Cecil				
c. LENGTH OF STAY IN 1b 6 hrs.					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital					d. STREET ADDRESS 603 Maryland Ave.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last John R. Thomas					4. DATE OF DEATH Month Day Year 4 23 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 12, 1906		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Board of Education		11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME R. B. Thomas					14. MOTHER'S MAIDEN NAME Virginia Belle Mayon				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 301-01-5810				
17. INFORMATION Address 003 Maryland Ave. Mrs. Gertrude V. Thomas, Elkton, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Gangrene Small bowel (b) Mesenteric Artery occlusion (c) Arteriosclerosis DUE TO DUE TO DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 4/23, 1967, to 4/25, 1967, that (I) (we) last saw the deceased alive on 4/23/67, and that death occurred at 12:12 PM, from the causes and on the date stated above.									
22a. SIGNATURE John A. Fischer 22b. DATE SIGNED 4/23/67 22c. PHYSICIAN'S NAME (Type) John A. Fischer 22d. ADDRESS ELKTON, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/27/67 23c. NAME OF CEMETERY OR CREMATORY Grape Vine Cemetery 23d. LOCATION (City, town or county) (State) Madisonville, Kentucky									
24. FUNERAL DIRECTOR Ralph E. Hicks Hicks Home for Funerals, Elkton, Md. 25a. REC'D BY REGISTRAR MAY 1 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge									

05082

05082

Cecil

Cecil

Alphon

Alphon

608 Maryland Ave.

Union Hospital

Dec. 18, 1903

Male

Board of Education of City

Maintenance

Alphon

R. F. Thomas

301-01-3010 Ave. Westward 7. Thomas, Alphon

9

May 1 1907  
Alphon  
Union Hospital  
608 Maryland Ave.  
Dec. 18, 1903

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05054

## CERTIFICATE OF DEATH

05053

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>101 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace,</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital</b>		d. STREET ADDRESS <b>612 Chapel Terrace</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>C.</b> Last <b>VICARI</b>		4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-6-96</b>
9. AGE (In years lost birthday) yrs. <b>70</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b>	11. IF UNDER 24 HRS. Hours <b>2</b> Min. <b>16</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boat Operator-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Boating</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>MICHAEL - Deceased</b>	
14. MOTHER'S MAIDEN NAME <b>Rose Jackson - Deceased</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>	
16. SOCIAL SECURITY NO. <b>220-20-7959</b>		17. INFORMANT <b>VA Hospital Records - Perry Point, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia Bilateral</b> <b>1621</b> DUE TO <b>Bronchogenic Carcinoma of rt lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <b>Chronic Pulmonary Emphysema</b> lost. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Pulmonary Emphysema</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7-10 days</b> <b>2-6 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>12 21 66</b> , 19 <b>67</b> , to <b>4 2 67</b> , 19 <b>67</b> , and that death occurred at <b>2:55 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>S. Goldgraben</b>		22b. DATE SIGNED <b>4-3-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. GOLDGRABEN, M.D.</b>		22d. ADDRESS <b>VA Hospital - Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4/5/67</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Havre de Grace, Md.</b>
24. FUNERAL DIRECTOR <b>PENNINGTON &amp; SON FUNERAL HOME - Havre De Grace Md.</b>		25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05055

CERTIFICATE OF DEATH

05054

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Pinellas</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ekron</u>		c. LENGTH OF STAY IN lb <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		d. STREET ADDRESS <u>9473 110 th. St. North</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James C. WARREN</u>		4. DATE OF DEATH Month Day Year <u>April 29 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 19, 1908</u>
9. AGE (In years last birthday) yrs. <u>59</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Toll Collector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James S. Warren</u>		14. MOTHER'S MAIDEN NAME <u>Lillie M. Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Agnes B. Warren</u>		Address <u>9473 110th St. North Largo Fla.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion with Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>11 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>—</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> 19 <u>—</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that (I) (this hospital) attended the deceased from <u>8 April 1967</u> , to <u>29 April 1967</u> , that (I) (we) lost saw the deceased alive on <u>8 April 1967</u> , and that death occurred at <u>2:45 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Klaus H. Huebner</u>		22b. DATE SIGNED <u>4/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>KLAUS H. HUEBNER</u>		22d. ADDRESS <u>NORTH EAST, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peterburg, Fla.</u>	23d. LOCATION (City or town) (County) (State) <u>St. Petersburg, Fla.</u>
24. FUNERAL DIRECTOR <u>Grant Funeral Home</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

05051

MINISTRY OF HEALTH

05051

MAY 8 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05056

CERTIFICATE OF DEATH

05055

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural		c. LENGTH OF STAY IN 1b 40-Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural		d. STREET ADDRESS U.S. Route #1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rush Canada Webb		4. DATE OF DEATH April 24, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/5/1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR, Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Ret.		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (County & State, or foreign country) Grundy, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lafayette Webb		14. MOTHER'S MAIDEN NAME Lydia VanDyke	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 198-07-8632A	
17. INFORMANT Mrs. Laura Webb (Wife)		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach with Metastasis 151X DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6-Months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/16/1967 to 4/24/1967, that (I) (we) last saw the deceased alive on 4/24/1967, and that death occurred at 6:15 P.M., from causes and on the date stated above.			
22a. SIGNATURE James L. Johnson		22b. DATE SIGNED 4/25/67	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 E. High Street, Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-27-1967	
23c. NAME OF CEMETERY OR CREMATORY Brookview Cem.		23d. LOCATION (City or Town) (County) (State) Rising Sun, Cecil Md.	
24. FUNERAL DIRECTOR J. H. Mullon Dir. 1950		25a. REC'D BY REGISTRAR APR 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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U.S. House of Representatives

U.S. House of Representatives

Robert Turner

Robert Turner

Robert Turner

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05057

## CERTIFICATE OF DEATH

05056

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>RD# 1 Box 91</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES V. WEST</b>		4. DATE OF DEATH Month Day Year <b>April 3 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-5-94</b>
9. AGE (In years last birthday) yrs. <b>72</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>72</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nursing Aide retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Rugby, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Floyd West (D)</b>		14. MOTHER'S MAIDEN NAME <b>Theodosia Blevins (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>219-30-2257</b>	
17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer--left mediastinum region</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>March 30</b> , 19 <b>67</b> , to <b>April 3</b> , 19 <b>67</b> , and that death occurred at <b>7:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Irina Reus</b>		22b. DATE SIGNED <b>4-3-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>IRINA REUS, M.D.</b>		22d. ADDRESS <b>VAH, Perry Point, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>4/7/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ashbury</b>	23d. LOCATION (City or Town) (County) (State) <b>Near Perryville Md.</b>
24. FUNERAL DIRECTOR <b>Pennington &amp; Son, Havre de Grace, Md.</b>		25. REGISTERED BY REGISTER <b>APR 11 1967</b> DATE	
26. REGISTERAR'S SIGNATURE <b>John Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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• All , books of travel , notes & maps



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05058

## CERTIFICATE OF DEATH

05057

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN lb <b>6- Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>237 E. High Street</b>		e. STREET ADDRESS <b>237 East High</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Edward Williams</b>		4. DATE OF DEATH Month Day Year <b>4 3 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1892</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Mill</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank D. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Ryan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Elizabeth M. Williams (Wife)</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach with Metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>this hospital</del> attended the deceased from <b>Oct. 24, 1966</b> to <b>April 3, 1967</b> , that (I) <del>last</del> saw the deceased alive on <b>April 3, 1966</b> , and that death occurred at <b>10P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>James L. Johnson</i>		22b. DATE SIGNED <b>4/4/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>James L. Johnson M.D.</b>		22d. ADDRESS <b>245 E. High St., Elkton Cecil Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/8/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pisgah Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Summitt Bridge, Del.</b>
24. FUNERAL DIRECTOR <i>Edwin R. Bell</i>		ADDRESS <b>909 Poplar St.</b>	
25a. REC'D BY REGISTRAR <b>APR 12 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event within 72 hours after death.

05057

05057

STATE OF TEXAS

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

NOTARY PUBLIC

My Commission Expires \_\_\_\_\_

IN WITNESS WHEREOF, I have hereunto set my hand and seal this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

Notary Public

My Comm. Expires \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

Notary Public

My Comm. Expires \_\_\_\_\_

Notary Public

My Comm. Expires \_\_\_\_\_

Notary Public

My Comm. Expires \_\_\_\_\_

Notary Public

My Comm. Expires \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05058					05058				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Cecil MARYLAND					a. STATE Penna. b. COUNTY Chester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford				
c. LENGTH OF STAY IN 1b 1 week					d. STREET ADDRESS R.F.D. # 1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Mrs Sara H. Williams					4. DATE OF DEATH Month Day Year April 8, 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5, 1874		9. AGE (In years last birthday) 92	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Olyphant, Fayette Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Jacob Humbert					14. MOTHER'S MAIDEN NAME Susan Hunter				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.					16. SOCIAL SECURITY NO. None		17. INFORMANT Frederick E. Williams		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY Hemorrhage 491X DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) EXTENSIVE RIGHT LOBAR PNEUMONIA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE PYELONEPHRITIS					INTERVAL BETWEEN ONSET AND DEATH 7 DAYS				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1965, 19, to 8 APRIL, 1967, that (I) (we) last saw the deceased alive on 7 APRIL 1967, and that death occurred at 7:15 AM, from the causes and on the date stated above.									
22a. SIGNATURE Robert L. Gray					22b. DATE SIGNED 8 APRIL 1967		22c. PHYSICIAN'S NAME (Type) Robert L. Gray		
22d. ADDRESS Elkton, Maryland					22e. REC'D BY REGISTRAR APR 11 1967				
22f. REGISTRAR'S SIGNATURE Charles Judge									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4-11-1967		23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		23d. LOCATION (City, town or county) (State) Oxford, Chester Co. Pa.		
24. FUNERAL DIRECTOR Richard L. Goodie Rising Sun, Md					25a. REC'D BY REGISTRAR APR 11 1967				
25b. REGISTRAR'S SIGNATURE Charles Judge									

05052

05052

Local

Station

Union Township

Mr. Sarr

Yamnia, Ohio

Housenry

Own home

Olyphant, Fayette Co. Pa. U.S.A.

Jacob Humphrey

None

Fredrick A. Williams

Newark, Del.

Robert A. Gray

4-11-1957

Oxford Cemetery

Apr 11 1957

Oxford, Chester Co. Pa.

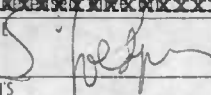
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #23a,b,c & d Film #G388 5/8/67 pc  
**CERTIFICATE OF DEATH**

05060

05059

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Newark</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VAH., Perry Point, Maryland</b>			d. STREET ADDRESS <b>Academy Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>KARL L WILLIS</b>			4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-12-01</b>	9. AGE (In years lost birthday) <b>65 yrs.</b>	IF UNDER 1 YEAR Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Wilmington, Delaware</b>	
13. FATHER'S NAME <b>Thomas J. Willis (D)</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>			16. SOCIAL SECURITY NO. <b>222-01-7746</b>		17. INFORMANT Address <b>VA Hospital records, Perry Point, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Arteriosclerosis, generalized</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6-8 days</b>  <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral arteriosclerosis</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>April 7</b> , 19 <b>67</b> , to <b>April 25</b> , 19 <b>67</b> and that death occurred at <b>1:00M</b> , from causes on and on the date stated above.					
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4-25-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. GOLDGRABEN, M.D.</b>		22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/29/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Newark Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Newark New Castle Delaw.</b>	
24. FUNERAL DIRECTOR <b>Robert T. Jones</b>		ADDRESS <b>Robert T. Jones Funeral Home, Newark, Delaware</b>		25a. REC'D BY REGISTRAR <b>MAY 1 1967</b>	25b. REGISTRAR'S SIGNATURE 

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 05060

05061

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 8 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Nursing Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Lydia A.B. WILLIS		4. DATE OF DEATH April 30, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1880
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore H. Brown		14. MOTHER'S MAIDEN NAME Sarah A. Churchman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Mrs. Lillian B. Watkins 1982 Nottingham Rd. Newark, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Arteriosclerotic cardiovascular disease with senile psychosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 14, 1962, to April 30, 1967, that I last saw the deceased alive on April 30, 1967, and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		ADDRESS (Street, city or town, state) 233 E. MAIN ST. DATE SIGNED May 1, 1967	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D.		Elkton Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/3/67	22c. NAME OF CEMETERY OR CREMATORY Rosebank Cem.	22d. LOCATION (City, town, or county) (State) Calvert, Md.
23. FUNERAL DIRECTOR'S SIGNATURE R. T. Jones		ADDRESS Newark, Delaware	
24a. REC'D BY REGISTRAR MAY 5 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

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James Thompson, 2200

23a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/>	23b. DATE THEREOF 4-24-67	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat Cemetery, Arlington, V.A.	23d. LOCATION (City or Town) (County) (State) Arlington, V.A.
24. FUNERAL DIRECTOR Lloyd Lewis Funeral Home, Alexandria, Va.		25a. REC'D BY REGISTRAR APR 19 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

VR A15 (4)  
25M 1/67

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155-10-1791 VA Hospital Records, Army, 1941, Md.

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